Montana Continuation HRSA State Planning Grant

Final Report to the Secretary

U.S. Department of Health and Human Services

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EXECUTIVE SUMMARY

In the summer of 2002 Montana was awarded its first State Planning Grant (SPG). While the original grant award was for one year, it was extended to two years. The purpose of that grant was to create a state database of information on the state's uninsured population (children and adults). This was accomplished through focus groups (four consumer groups and two employer groups), surveys (household and employer), and 30 key informant interviews. The results of that grant, including the series of recommendations on how to cover more of Montana's uninsured population, are contained in two documents: the *Montana Strategic Plan to Provide More Affordable Health Care Coverage* (Summary of the Montana State Planning Grant Recommendations, August 2004*)* and the *Final Report to the Secretary*, Spring 2004 (see Appendix II).

In September 2005, Montana was awarded a continuation or second SPG. The purposes of this continuation grant were to: (1) analyze the impact of current legislative initiatives that expand health coverage for the uninsured; (2) develop sustainable methods to gather information about health insurance for the population in total and information related to employer-based health insurance; and (3) create a "home" for continuing health policy development that addresses providing health care coverage to all Montanans.

In 2005, the Director of the Department of Public Health and Human Services (DPHHS) appointed a 24-member SPG Steering Committee to create a comprehensive plan with specific short- and long-term actions that would lead to accessibility of affordable high quality health care coverage for all Montanans by the Year 2012. Also, a multidisciplinary Project Work Team including staff from DPHHS, the Department of Labor and Industry (DOLI), and from the State Auditor's Office (SAO) (also known as the Insurance Commissioner's Office) was chosen to assist the grant director and contractors to: (1) continue to refine and create a sustainable source of data on the insurance status of Montanans, including employer-based insurance; (2) analyze the impact of current policies and programs influencing access to health care coverage; and (3) develop and recommend possible policy options for consideration by the Steering Committee.

DPHHS contracted with the University of Montana's (U of M) Bureau of Business and Economic Research (BBER) to:

1. conduct a follow-up of the employer survey, implemented during the state's first state planning grant;
2. analyze the survey data and prepare/present a final report; and
3. assist in the preparation of the final grant report.

DPHHS also contracted with the University of Minnesota's State Health Access Data Assistance Center (SHADAC) to:

1. review and advise on the University of Montana's follow-up employer survey, Montana's Behavioral Risk Factor Surveillance System (BRFSS) questionnaire, and a potential future DOLI employer survey;
2. develop an evaluation data plan for the 2005 legislative health coverage access initiatives (developed from the 2004 SPG recommendations) that became law;

3. develop an issue brief describing Montana's and other frontier states' health care initiatives and programs; and
4. generally provide technical assistance to the grant director, steering committee and project team, with a formal presentation of contract products as well.

All documents from both universities have been submitted to and accepted by the State of Montana.

This Final Report also incorporates findings from the 2004 and 2005 BRFSS. During the continuation grant, instead of administering another household survey (similar to the one paid for by the first SPG), the most up-to-date data from the BRFSS were analyzed, and additional questions about health care access to the core questionnaire were added for future administrations of the survey.

During this continuation grant, five formal Steering Committee meetings, a statewide videoconference/public hearing and numerous conference calls and informal small group meetings of Steering Committee members and Project Team members over a period of 15 months, also yielded 12 recommendations.

The Steering Committee has produced a document, the 2006 *Final Steering Committee Report,* which includes the recommendations/policy guidance on how to promote accessible, affordable, and high-quality health care and coverage for all Montanans. They are as follows:

- Continue to support the current infrastructure that provides data on the uninsured (two recommendations);
- Continue the weaving of Native Americans into all policy direction;
- Expand coverage to target populations (two recommendations);
- Expand pooling;
- Promote cost avoidance through prevention (two recommendations);
- Expand the safety net;
- Expand eligibility in public health care programs (two recommendations); and
- Value and build the health care workforce.

More information about the recommendations can be found in the 2006 *Final Steering Committee Report* (see Appendix II).

In summary, as a result of this continuation grant, Montana policy makers will, in the future, have the guidance of:

- the SHADAC BRFSS memos which not only provide BRFSS questions from other state BRFSS instruments, but also provide specific (for Montana) recommended individual health care related questions, employer specific questions and questions to measure health care coverage of children;

- the SHADAC report on health insurance access programs and policies in Montana and other frontier states plus a supplemental report on additional state initiatives to improve health insurance coverage;
- a SHADAC memo on ways of monitoring trends in employer-sponsored health insurance data in Montana;
- a data evaluation plan for use with the 2005 legislative initiatives;
- the findings and analysis of the follow-up 2006 Employer Survey; and
- recommendations from the SPG Steering Committee.

These grant products are all available on the DPHHS website (see Appendix II).

Because of the SPG program available from HRSA, Montana has finally been able to create a database of information about its uninsured residents. A continuation of this type of federal funding either annually or at least every other year would benefit the state so that the data collection assuredly continues and the private-public sector collaboration continues to evolve a solution that will work for Montana. Focusing available potential federal dollars on identifying not only the uninsured, but the underinsured, and how to improve access to health care coverage would be most beneficial to Montana at this point in time and in the near future.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

The purpose of Section 1 is to describe in detail the characteristics of the uninsured in the State of Montana and to indicate the strategies used to obtain this information. Undertaken in the first grant were the questions: who the uninsured are and why they are uninsured. These questions were addressed in detail through the surveys, focus groups, and key informant interviews.

Because a focus of this continuation grant was to assess the status of employer (especially small employer) health insurance, this continuation grant contracted for an updated employer survey again from the University of Montana. However dollars were not available in this grant to conduct another household survey. Instead, one of the data collection strategies the State of Montana has adopted to monitor the uninsured over time using an existing database is to augment the Montana BRFSS survey instrument with additional questions regarding health care coverage, both in the 2006 survey cycle which has just ended and in the upcoming 2007 BRFSS survey. A list of questions added to both years of the survey is found in the document entitled *Suggested Questions to Include in Subsequent Montana BRFSS Questionnaires* (see Appendix II). While the SPG HRSA continuation dollars were used to add questions to the 2006 and 2007 surveys, state funding to support these added questions has not yet been secured for future years of data collection.

The following summarizes Montana's uninsured population and health insurance coverage access from the most recently available data from BRFSS. Further information about the uninsured is derived from DPHHS staff analyses of the Montana BRFSS 2004 and 2005 data files and from the 2003 Household (HH) Survey conducted during the first SPG. In addition, the University of Arkansas provided the state with information about Montana's uninsured using the Multi-State Integrated Database. Particularly useful from this source of data were the Current Population Survey (CPS) summarized data and the select data tables below.

Findings presented below are related to all of the coverage options that the State of Montana has selected during this continuation SPG, except the first recommendation dealing with continuing to support the infrastructure to evaluate, monitor and sustain this work. See the summary of those options listed at the end of the Executive Summary above and in more detail in the 2006 *Final Steering Committee Report* (see Appendix II).

1.1 What is the overall level of uninsurance in your State?

***Per 2004 CPS*:** 19.1% of all Montanans (174,223 children and adults);
Per 2004 BRFSS: 19.2% of adults (134,237);
Per 2005 BRFSS: 21.5% of adults (152,135).

1.2 What are the characteristics of the uninsured?

The tables in Section 1.2 define characteristics of Montana's uninsured residents.

INCOME, AGE, GENDER, HEALTH STATUS, EMPLOYMENT STATUS, RACE/ETHNICITY, GEOGRAPHIC LOCATION, AND DISABILITY STATUS:

Table 1. Uninsurance Rates for Adult Montanans (18 years and older) by Key Demographic Characteristics

	2004			2005		
Characteristic	**% Uninsured**	**CI**	**Pop. Est.**	**% Uninsured**	**CI**	**Pop. Est.**
ALL ADULTS:	19.2	17.6-20.8	134,237	21.6	19.8-23.3	152,135
Income:						
<$15,000	33.8	28.2-39.5	22,474	37.6	31.4-43.8	23,465
$15,000 - $24,999	35.8	31.5-40.2	45,789	36.1	31.6-40.5	43,812
$25,000 - $49,999	16.4	13.8-19.0	37,228	21.1	18.0-24.1	46,712
$50,000 - $74,999	6.0	3.9-8.1	6,739	9.8	6.0-13.6	10,666
$75,000+	6.8	3.6-9.9	5,905	7.0	4.1-9.9	6,901
Age:						
18 - 24	38.6	31.0-46.1	35,404	39.5	31.4-47.7	36,736
25 - 34	27.4	22.9-31.8	28,085	30.8	25.8-35.7	32,953
35 - 44	18.2	15.3-21.1	24,044	22.1	18.7-25.4	27,169
45 - 54	18.4	15.7-21.1	26,674	21.2	18.0-24.3	30,410
55 - 64	17.8	14.8-20.8	17,777	18.2	15.2-21.2	19,374
65+	1.1	0.5-1.8	1,390	3.5	2.2-4.7	4,442
Gender:						
Male	21.4	18.9-23.9	73,978	23.2	20.4-26.1	80,952
Female	17.0	15.1-18.9	60,259	19.8	17.7-21.9	71,183
Health Status:						
Excellent	17.7	14.2-21.3	29,163	16.6	13.4-19.7	26,118
Very good	17.5	14.9-20.0	41,124	18.8	16.0-21.7	44,769
Good	21.2	18.2-24.2	44,089	26.6	22.8-30.3	55,131
Fair	22.9	17.9-28.0	13,944	24.4	19.7-29.2	16,938
Poor	16.4	10.7-22.2	4,706	27.9	18.9-36.9	8,913

Table 1 continued on next page.

Table 1 continued. Uninsurance Rates for Adult Montanans (18 years and older) by Key Demographic Characteristics

Characteristic	2004			2005		
	% Uninsured	CI	Pop. Est.	% Uninsured	CI	Pop. Est.
Employment Status:						
Employed for wages	19.8	17.4-22.2	69,559	20.3	17.7-23.0	69,973
Self-employed	27.9	23.5-32.3	27,717	32.6	27.7-37.4	32,605
Out of work > 1 year	58.1	42.7-73.5	3,450	34.3	19.0-49.7	3,996
Out of work < 1 year	55.3	43.0-67.6	11,847	50.0	35.3-64.6	8,614
Homemaker	16.8	12.0-21.7	8,249	29.1	22.9-35.4	15,532
Student	13.2	6.1-20.3	3,904	24.3	12.2-36.3	6,845
Retired	3.0	1.9-4.2	3,525	7.3	5.4-9.3	9,022
Unable to work	19.9	13.2-26.6	5,166	18.2	12.1-24.2	5,130
Race/Ethnicity:						
White, non-Hispanic	17.8	16.1-19.4	112,008	20.4	18.5-22.2	129,563
Non-White or Hispanic	32.9	27.3-38.5	20,695	32.6	26.6-38.6	20,570
- AI/AN*	40.1	32.7-47.5	13,335	29.3	23.0-35.6	10,123
- Other or Hispanic**	24.8	16.4-33.3	7,360	36.5	26.0-47.1	10,448
Health Region:						
1- Eastern MT	17.4	13.7-21.1	9,703	20.8	17.0-24.6	11,890
2- North Central MT	19.1	15.2-23.0	19,497	19.6	15.9-23.3	19,985
3- South Central MT	19.2	15.6-22.9	27,577	17.8	13.7-21.8	25,311
4- Southwest MT	16.3	13.3-19.3	29,131	21.0	17.0-24.9	37,539
5- Northwest MT	21.9	18.8-25.1	46,063	24.4	21.1-27.6	52,083
Disability Status:						
Disability	16.6	13.8-19.4	22,262	24.3	20.0-28.6	37,198
No Disability	19.4	17.6-21.2	106,235	20.7	18.8-22.6	113,405

Source: 2004 and 2005 Montana BRFSS

**American Indian or Alaska Native Only*

*** All other non-White (including multiracial) or Hispanic*

Note:

- Regarding race/ethnicity, BRFSS data indicate a significant difference in uninsured Native Americans (40% in 2004) from White, Non-Hispanic (18% in 2004). These figures have not been adjusted for age and it should be noted that the Native American population in Montana is a younger and emerging population in comparison to the general Montana adult population. Therefore, since younger adults are more likely to be uninsured, age will play a partial though not complete role in the explanation of differences between the groups. Also, please refer to the third major category (entitled Weaving Integration of Native People into Every Action) of the recommendations in the 2006 *Final Steering Committee Report* (see Appendix II).
- Finally, regional breakdowns in the above table are based on the state's five health planning regions. Overall, the percentage of uninsured is not significantly among the adults within the five health planning regions. According to the 2003 Household survey, the percentage of uninsured is not significantly different between urban (21%) and rural (23%), though most Montanans live in rural areas.

FAMILY COMPOSITION:

Table 2. Family Composition by Insurance Status

Family Composition	National Estimates		Uninsured: Montana Population Estimates		Insured: Montana Population Estimates	
	Uninsured	Insured	#	%	#	%
Husband–wife family	49.2%	66.5%	80,093	46.0%	493,379	66.9%
Other female head	28.7%	22.6%	47,730	27.4%	154,441	20.9%
Other male head	22.1%	10.8%	46,400	26.6%	89,613	12.2%

Source: MSID CPS Estimates for 2004

AVAILABILITY OF PUBLIC COVERAGE:

According to the 2003 Household Survey approximately 25.3% of Montanans had public coverage, i.e., Medicare, Medicaid/CHIP.

Table 3. Private and Public Coverage Penetration in Montana, Adults and Children, 2000 and 2003

Insurance Coverage/Source	2000	2003	Increase (Decrease)	% Increase or Decrease	2000 % of Population	2003 % of Population
Private Health Insurance	525,397	510,760	(14,637)	-2.8%	58.2%	55.7%
Medicare	136,726	142,457	5,731	4.2%	15.2%	15.5%
Medicaid and CHIP	74,970	90,056	15,086	20.1%	8.3%	9.8%
Uninsured	165,102	174,348	9,246	5.6%	18.3%	19.0%
Total Population	902,195	917,621	15,426	1.7%	100.0%	100.0%

Source: Russell Hill, DPHHS

Includes offered but not accepted. Also, see results from 2003 Household Survey (see Appendix II).

IMMIGRATION STATUS:

Table 4. Immigration Status by Insurance Status

Immigration Status	National Estimates		Uninsured: Montana Population Estimates		Insured: Montana Population Estimates	
	Uninsured	Insured	#	%	#	%
Native, born in U.S.	72.7%	89.3%	172,116	94.8%	726,316	99.5%
Native, born in Puerto Rico or U.S. outlying area	0.7%	0.5%	0	0.0%	0	0.0%
Native, born abroad of American parent(s)	0.8%	0.7%	2,107	1.2%	3,776	0.5%
Foreign born, U.S. citizen by naturalization	5.1%	4.6%	2,671	1.5%	0	0.0%
Foreign born, not a U.S. citizen	20.8%	4.9%	4,669	2.6%	0	0.0%

Source: MSID 2004 CPS Data

DURATION OF UNINSURANCE:

Page 3 of the 2004 *Final Report to the Secretary* indicates from the 2003 Household Survey that 16% of the uninsured non-elderly Montanans were uninsured all year; another 5.7% were uninsured intermittently during the year; and 3.7% were intermittently without insurance coverage but were currently insured at the time of the interview.

With this continuation grant, two new questions were added to the 2006 BRFSS survey regarding health care coverage. One question specifically asks the respondent: "About how long has it been since you had health care coverage?" In the summer of 2007, when BRFSS staff receive the dataset from their CDC partners, the data will be available for analyses.

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Children, working parents and caretakers of dependent children, formerly non-Medicaid eligible individuals with severe emotional disturbance, small employers (with 7-9 employees), and high-risk pools were all important population groupings included in Montana's coverage expansion options. Please refer to the report entitled *Health Insurance Access Programs and Policies in Montana and Other Frontier States* as completed by SHADAC during this continuation grant period (see Appendix II). This report summarizes the target groups and eligibility criteria for expansion options recently adopted by Montana.

Questions 1.4 through 1.13 focus primarily on the qualitative research work conducted by the State:

1.4 What is affordable coverage? How much are the uninsured willing to pay?

During the current continuation grant, qualitative research was not conducted. However, the following information was clear from the results of the 2003 Household Survey:

- Of those who are uninsured 90% are forced to be uninsured, mostly because of price (81%). Being uninsured is not voluntary.
- Of those who are uninsured most believe they can afford $96 per month for insurance.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

This was not asked during this continuation grant. See 2003 HH survey and focus group interviews conducted during the first SPG (see Appendix II).

1.6 Why do uninsured individuals and families disenroll from public programs?

This was not asked during this continuation grant. See 2003 HH survey and focus group interviews conducted during the first SPG (see Appendix II).

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

When asked this question in both the 2003 and the 2006 Employer Survey conducted by the University of Montana's BBER, two thirds of the employers thought or knew that those employees were covered by another plan. Twenty-six percent of the employers cited high insurance premium costs and the affordability of insurance as the main reason some of their workers didn't use the firm's health insurance plan. Two to three percent of the employers felt those employees didn't think they needed insurance and five to six percent cited a variety of other reasons. See the table under question 2.1 for further discussion of this. Also, see the final reports for the employer surveys (see Appendix II).

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

See 2003 HH survey and focus group interviews conducted during the first SPG (see Appendix II). Also, see answer to this question on page 8 of 2004 *Final Report to the Secretary* (see Appendix II).

1.9 How likely are individuals to be influenced by: Availability of subsidies? Tax credits or other incentives?

For answers to these questions, please refer to answer to question 2.6.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

As part of the continuation grant, the SPG added two state questions to the 2006 BRFSS, one of which was, "What is the main reason you are without health care coverage?" These data will be available in the summer of 2007. See DPHHS website document for the complete survey questions and response categories. Also see 2003 HH survey and focus group interviews conducted in first SPG and the answer to this question in the 2004 *Final Report to the Secretary* (see Appendix II).

1.11 How are the uninsured getting their medical needs met?

This was not addressed in this continuation grant.

See 2003 HH survey and focus group interviews conducted during the first SPG and the answer to this question in the 2004 *Final Report to the Secretary* (see Appendix II).

From recent BRFSS analyses, persons aged 18-64 who do not have health care coverage are much less likely to have a personal health care provider. That is, of persons aged 18-64, 78% who have health insurance have a personal provider while just 49% without health insurance have a personal provider. While most adult Montanans have a personal health care provider, 22-25% report that they do not. Persons who do not have a personal health care provider are much less likely to receive important preventive health services. See the following table as an example of these differences in practice of preventive health care for persons who have a personal physician versus those who do not have a personal physician:

Table 5. Preventive Care Utilization Among Montana Adults

Engaged in Preventive Health Care	Have Personal Physician		No Personal Physician	
	%	CI	%	CI
Adult aged 65 and older:				
Had Influenza Vaccine	74.1%	70.6-77.2	53.4%	41.1-65.3
Had Pneumoc. Vaccine	73.5%	69.9-76.8	51.6%	39.3-63.6
Adults aged 50 and older:				
Had sigmoid/colonoscopy (insured)	58.7%	56.0-61.3	29.4%	22.8-37.0
Had sigmoid/colonoscopy (uninsured)	33.1%	25.3-42.0	17.7%	10.6-27.9
Women aged 40 and older:				
Had Mammogram (insured)	77.9%	75.3-80.2	55.1%	46.3-63.5
Had Mammogram (uninsured)	54.5%	45.9-62.7	29.3%	19.2-42.0

Source: 2004 Montana BRFSS

1.12 What are the features of an adequate, barebones benefit package?

This was not addressed during this continuation grant. See 2003 HH survey and focus group interviews conducted during the first SPG, and the answer to this question in the 2004 *Final Report to the Secretary* (see Appendix II).

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

At various times during the Steering Committee meetings in particular there was discussion about how to define which Montanans are "underinsured" and then measure Montana's "underinsured." To further their understanding of this group, the Steering Committee participated in a conference call with SHADAC. The conclusion of that discussion was a need for more study and definition of "underinsured," "access," and "coverage."

To date the only Montana data with some focus on the "underinsured" comes from the BRFSS data. A respondent is identified as underinsured if s/he answered "yes" to: "Do you have any kind of health care coverage…? (core question) and "yes" to: "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" (core question). According to the results of the 2005 BRFSS, 45,833 adults (6.5% of the adult population) were identified as underinsured, i.e., people with insurance but who could not see a doctor in the past year because of cost.

Also, see answer to this question in 2004 *Final Report to the Secretary* (see Appendix II).

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

The answers in Section 2 document the University of Montana's BBER research activities related to employer-based health care coverage during the first grant (e.g., the 2003 Employer Survey) and via the 2006 Employer Survey (as part of continuation grant) as well as how this information informed the State's decisions on how to expand health insurance coverage.

The 2006 Montana Employer Survey was a repeat stratified random telephone survey of businesses located in Montana covered by unemployment insurance. The firms that were no longer in business since the 2003 survey were replaced with firms that started since May of 2003. The 2006 survey was completed by 486 employers, 418 of which also completed the 2003 survey. The data were collected by the Survey Research Center at the University of Montana-Missoula, BBER, from January 2006 to March 2006. The data were weighted so that results are representative of all Montana employers. Findings from both surveys are discussed and analyzed in this report. See Appendix II for the final reports from each of these surveys.

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do (in terms of employer size, industry sector, employee income brackets, percentage of part-time and seasonal workers, and geographic location)?

About half of all Montana employers offered health insurance to their employees in 2003, a rate that had not changed by 2006. Although the overall offer rate of health insurance by employers did not change over the three year period there was a change in the percentage of employers offering insurance to <u>all</u> of their employees.

The high cost of health insurance and the workforce size of employers (Tables 6 and 7) were major determinants for offering job-based health insurance in Montana. The offer rate or percent of firms offering health insurance increased with a firm size. Very small firms with 5 employees or less were the least likely to offer health insurance. In 2003, 63 percent of these small firms did not offer health insurance, a rate that decreased slightly to 60 percent in the 2006 survey. Forty eight percent of Montana firms with 6 to 10 employees offered health insurance to their employees in both 2003 and 2006. Larger firms were more likely to offer health insurance to their workers. Firms with 100 or more employees was the critical size threshold for offering health insurance with firms in this category offering health insurance to their workforce.

Cross tabs on offering health insurance and industry (using NAICS) did not show any significant variation in the industry patterns of offering health insurance. Cross tabs on offering health insurance and geographic areas (using ZIP codes) did not show any significant variation in the geographic patterns of offering health insurance.

No information was collected from the 2006 employer survey on part-time or seasonal workers or on income and wage levels of employees. There are data on these items from the 2003 Montana Household Survey.

Table 6: Employer-Sponsored Health Insurance Offers, by Firm Size – Montana, 2003 (n=520)

Firm Size	No Insurance Offer	Offer to Some Employees	Offer to All Employees
1-5 employees	63%	10%	27%
6-10 employees	48%	15%	37%
11-19 employees	28%	19%	53%
20-100 employees	20%	34%	46%
101+ employees	4%	47%	49%

Source: 2003 MT Business Insurance Survey, Bureau of Business and Economic Research, University of Montana.

Table 7: Employer-Sponsored Health Insurance Offers, by Firm Size – Montana, 2006 (n=486)

Firm Size	No Insurance Offer	Offer to Some Employees	Offer to All Employees
1-5 employees	60%	6%	34%
6-10 employees	47%	2%	51%
11-19 employees	31%	11%	58%
20-100 employees	17%	5%	78%
101+ employees	2%	6%	92%

Source: 2006 Employer Survey on Health Insurance in Montana, Bureau of Business and Economic Research, University of Montana

WORKFORCE COVERAGE, BENEFITS AND COSTS

Health insurance is not offered to all workers. Small firms offered coverage to a smaller portion of their employees while larger firms offered insurance to a higher proportion of their work force, although not always to their entire work force. There was an improvement in the percent of firms offering insurance to all employees between 2003 and 2006.

Ninety percent of those Montana employers who offered health insurance in 2006 offered it to all their employees compared to seventy percent in 2003. There are some qualifications, however, to this apparent gain in insurance offering. First, the percent of employers offering insurance who offered it to all workers significantly varied by size of the firm. And second, there was dramatic cost shifting of health insurance premiums by employers to workers.

The percent of firms offering health insurance to all employees (see Tables 6 and 7) increased for all firm size classes over the three-year period. Larger firms of 20 or more employees showed especially strong gains in offering insurance to all workers increasing from thirty seven percent of all firms in this size category in 2003 to fifty one percent offering health insurance to all their workers by 2006.

Not all of this was a positive gain on insurance coverage rates. Although health insurance was offered to a higher proportion of employees over the three years, these gains were

offset by a disproportionate shifting of higher health insurance premiums onto employees.

Montana employers' offering of health insurance between 2003 and 2006 was remarkably stable with no dramatic changes in the proportion of employers offering health insurance to their employees. Twenty-two percent of the 418 employers in both surveys did not offer health insurance in 2003 or in 2006.

The stability of the employer health insurance offer rate is reflected in net change measures in the employer offer rate. Six percent of the 418 employers surveyed in both years added health insurance as a benefit over this three year period while another six percent of the employer sample offered health insurance in 2003 but dropped it by 2006.

In the 2006 survey eighty percent of the firms offering health insurance had 30 hours or more as the weekly work requirement for health coverage. Sixty five percent of the employers in 2006 required at least 3 months on the job before an employee was eligible for health insurance and there was a significant cluster of firms requiring a six month on the job waiting period.

Employers continue to offer dental and prescription drug coverage in their employee health plans. Forty seven percent of the employers offering health insurance include dental coverage in their health plan. Seventy four percent offer prescription drug coverage to their employees as part of the health insurance plan.

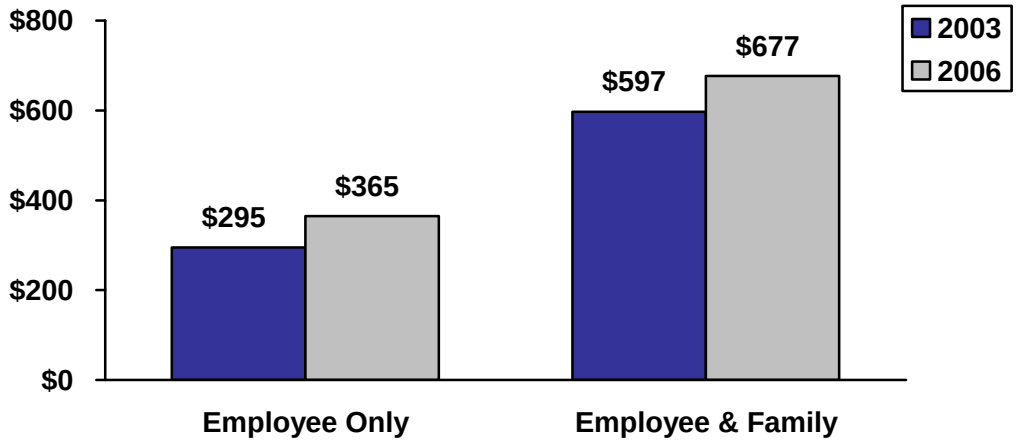
For those employers offering coverage, please discuss the following: Cost of policies, level of contribution, and percentage of employees offered coverage who participate.

COST OF POLICIES

Healthcare and health insurance cost increases show up in the premiums paid by employers. Higher health insurance premiums affect not only the employer, however, but also the employee depending on by how much the employee's share of monthly premiums increase.

Dollar costs of health insurance for Montana workers and employers were measured in the survey (Figure 1) by monthly insurance premiums for 'employee only' coverage and for 'employee and family' coverage. The 2003 survey data showed that average monthly premiums for 'employee only' coverage was $295 and the 2006 survey data showed a mean value of $365 as the monthly premium. Average premium costs of family coverage went from $597 in 2003 to $677 per month by 2006.

Figure 1: Monthly Health Insurance Premiums for Montana Firms Offering Health Insurance, 2003, (n=228) and 2006 (n=222)



The dollar increase in monthly health insurance premiums in just three years was significant. 'Employee only' insurance increased by $70 per month while 'employee family' coverage increased by $80 per month. Both of these increases equal more than $800 per year higher health insurance costs and approach $1,000 annually for the 'employee plus family' coverage.

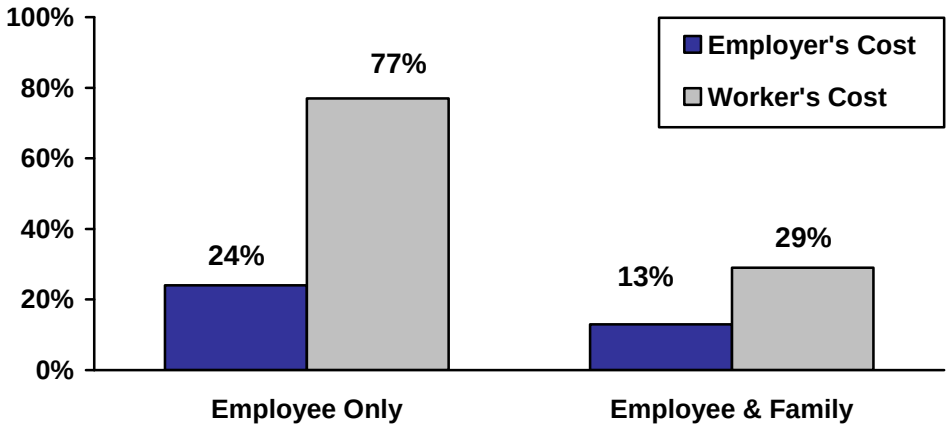
LEVEL OF CONTRIBUTION

Employers' responses to higher health insurance premiums have been to shift most of the increased health insurance premium costs to employees. Cost shifting to employees occurred by increasing the monthly dollar amount paid by the employee, increasing the amount of the plan's deductible, increasing the dollar amount of employee co-pay on visits or some combination of all three.

Higher employee monthly payments were the major approach to cost shifting onto workers. One third of employers experiencing higher insurance premiums increase said they increased the dollar amount paid by employees. The average dollar monthly payment by employees for single coverage went from $35 in 2003 to $62 dollars in 2006. Average monthly premium costs paid by employees for family coverage went from $122 to $156 per month over the same period.

The comparative cost shifting to employees can be seen in Figure 2 which shows percentage increases in costs on employers and cost increases experienced by employees in terms of their dollar share of the company's monthly premium costs. Single coverage monthly payments for workers increased by 77% in three years compared to the 24 percent cost increase to employers for that type of coverage. Employees with family coverage paid 29 percent more, more than double the percent increase of 13 percent for monthly premiums experienced by employers.

Figure 2: Percentage Change in Monthly Health Insurance Premium Costs for Montana Employers and Their Workers, 2003 to 2006



Employers are pessimistic about cost relief and expect health insurance costs to continue as a major economic concern. Two thirds of the employers offering health insurance thought that health insurance cost increases in excess of what they could afford was either 'very likely' or 'somewhat likely'.

Continued cost shifting to their employees was identified as the most likely strategy for dealing with rising health insurance costs. Seventy percent of the employers offering health insurance said it was either 'very likely' or 'somewhat likely' that they would shift higher insurance costs to employees. It seems reasonable, therefore, to expect a continuation of cost shifting of higher health insurance premiums to workers.
Other responses to higher costs such as reducing care choices or switching plans were explored for employers offering health insurance. Only a small percent (10 percent) of employers indicated that would pursue these options to cope with increasing costs for health insurance coverage.

Health insurance cost increases dominate most of the responses from employers in the job based insurance survey. Health insurance costs were a major concern to employers in 2003 and were also the focus three years later.

PERCENTAGE OF EMPLOYEES OFFERED COVERAGE WHO PARTICIPATE

The Montana Employer Survey did not collect information on the number/percentage of employees offered coverage who choose to participate. Montana employers were asked reasons why their eligible employees did not purchase the health insurance coverage offered (Table 8). Two thirds of the employers in both survey years thought or knew that their employees were covered by another plan. Twenty-six percent of the employers responding to this question in both survey years cited high premium costs and the affordability of insurance as the major reason some of their workers did not use the firm's health insurance plan.

Table 8: Montana's Employers' Views of Why Eligible Employees Do Not Use Firm's Health Insurance Coverage, 2003 and 2006

Reason	2003	2006
Can't afford premiums	26%	26%
Employees covered by another plan	66%	66%
Don't think they need insurance	2%	3%
Other reasons	6%	5%

Note: qualitative data were not collected in 2006. Responses to questions 2.2-2.7 are based on 2006 survey data instead.

2.2a What influences the employer's decision about whether or not to offer coverage?

Premium costs continually dominate employers' decisions on offering insurance, especially employers with 10 or fewer workers. Firms with 2 to 5 employees typically do not have the financial resources to pay for double digit annual increase in health insurance premiums occurring over the past five years. Larger firms with more financial capacity more frequently offer health insurance in order to attract and keep good workers. Most Montana firms with 100 or more employees offer health insurance. Some firms, regardless of size, feel that offering health insurance is almost a moral obligation they choose to fulfill due to a deep sense of personal responsibility or memories of earlier years when they, the employer, did not have health insurance coverage in previous jobs.

2.2b What are the primary reasons employers give for electing not to provide coverage?

Employer costs of health insurance premiums were identified as the major reason that employers either did or did not offer health insurance. Eighty one percent of the firms not offering insurance in 2003 thought premiums were too high and prevented firms from offering insurance, a response rate which had not diminished significantly by 2006. Nine percent of non-offering firms in 2003 thought employees were adequately covered by another plan somewhere else, a proportion that dropped to six percent in 2006. High turnover in the workforce was the reason that six percent of non-offering firms did not offer health insurance in 2003 and five percent saw turnover as the main reason in 2006.

Table 9: Why Montana Firms Do Not Offer Health Insurance Coverage

Reason	2003 (n=302)	2006 (n=249)
Premiums too high	81%	76%
Employees covered by another plan	9%	6%
Turnover too great	6%	5%
Other reasons	4%	13%

2.3a How do employers make decisions about the health insurance they will offer to their employees?

Cost is again a major decision factor affecting the offering as well as the employee's share of health insurance. Healthcare and health insurance cost increases show up in the premiums paid by employers. Higher health insurance premiums affect not only the employer, however, but also the employee depending on how much the employee's share of monthly premiums increase.

2.3b What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

Employers try to maintain adequate benefit packages by continuing to offer dental and prescription drug coverage in their employee health plans. Forty seven percent of the employers offering health insurance include dental coverage in their health plan. Seventy four percent offer prescription drug coverage to their employees as part of the health insurance plan. But the costs of such coverage are increasingly being shifted over to workers. The comparative cost shifting to employees can be measured by percentage increases in costs on employers and cost increases experienced by employees in terms of their dollar share of the company's monthly premium costs. The monthly cost paid by an employee for individual coverage increased by 77% in the three years between 2003 and 2006 compared to a 24 percent cost increase paid by employers for that type of coverage. Employees with family coverage paid 29 percent more, more than double the percent increase of 13 percent for monthly premiums experienced by employers.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

Montana employers are pessimistic about cost relief and expect health insurance costs to continue as a major economic concern. Employers offering health insurance thought that premium cost increases in excess of what they could afford was either 'very likely' or 'somewhat likely'. Continued cost shifting to their employees was identified as the most likely strategy for dealing with rising health insurance costs. Seventy percent of the employers offering health insurance said it was either 'very likely' or 'somewhat likely' that they would shift higher insurance costs to employees. It seems reasonable, therefore, to expect a continuation of cost shifting of higher health insurance premiums to workers. Other employer responses to higher costs such as reducing care choices or switching plans were also reported by employers offering health insurance. Only a small percent (10 percent) of employers indicated they would pursue these options to cope with increasing costs for health insurance coverage.

2.5 What employer and employee groups are most susceptible to crowd-out?

Small firms coping with unaffordable health insurance premiums are especially vulnerable to crowding out. Expansion of public programs such as Medicaid and CHIP, particularly through easing of financial eligibility requirements for families coupled with higher health insurance cost shares shifted onto workers will result in workers declining coverage at their place of employment. Workers declining coverage will lead to employers not continuing to offer insurance as a coping strategy for dealing with higher

health insurance costs. Employers of low wage workers who are income eligible for Medicaid and CHIP will be susceptible to crowd.

2.6 How likely are employers who do not offer coverage to be influenced by: Expansion/development of purchasing alliances? Individual or employer subsidies? Additional tax incentives?

The 2005 Montana legislative session passed the Small Business Healthcare Affordability Act. The measure, signed into law in May of 2005, enacted the Insure Montana Program, which provides tax credits and premium payments to small business owners for employee health insurance. The Act also provides for small business formation of purchasing pools designed to negotiate lower-priced health plans through group purchasing. The Employer Tax Credit is targeted on employers already providing health insurance who employ two to nine employees and where no employee is paid more than $75,000 per year (owner excluded). The tax credit cannot be more than 50% of premiums paid. To qualify for Premium Incentive and Assistance Payments employers of 2 to 9 employees cannot currently provide employee health insurance. Eligible employers also must go through the new State Health Insurance Purchasing Pool or another qualified Association Plan and cannot have an employee who is paid more than $75,000 per year (owner excluded).

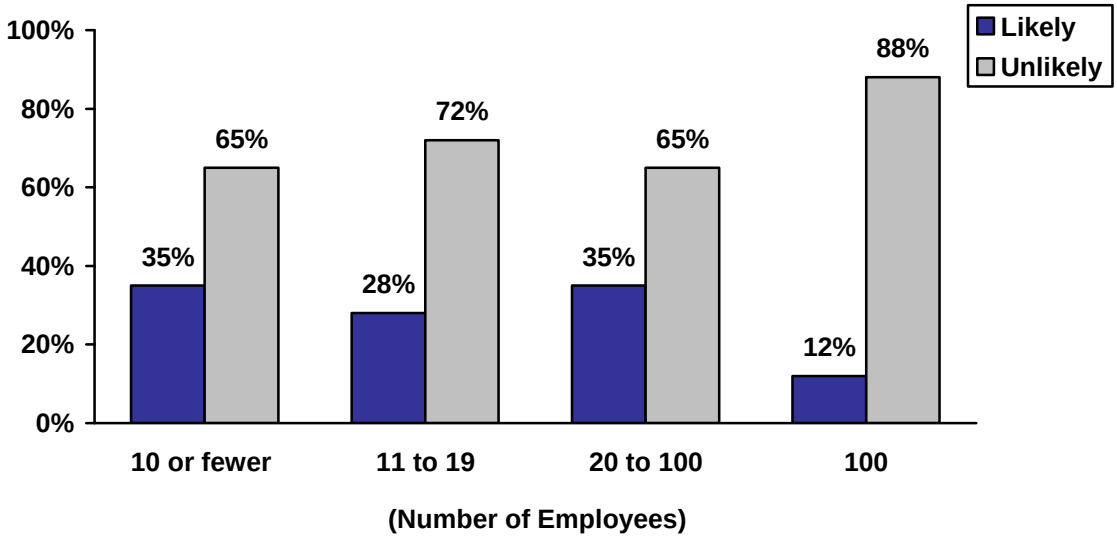
To update the original 2003 employer survey, questions were added in the 2006 survey about the Insure Montana Program. The questions covered the following areas: highest employee salary, dependent coverage, employer program awareness, and likely program enrollment by employer.

There was a high probability of employers participating in the State of Montana program in 2006. Sixty-eight percent of firms not offering insurance said they would be 'very likely' or 'somewhat likely' to participate in a tax credit or premium assistance/purchasing pool program. This high positive response to the program is consistent with the full subscription rates the program has experienced since starting operations in January 2006.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Alternatives to dealing with higher health insurance costs were explored. Firms were asked about providing cash payments for health insurance to workers who would then use it to buy health insurance coverage in lieu of the employer continuing to negotiate with health insurance companies. This was not a very attractive option to most employers and it became less attractive for large firms (see Figure 3).

Figure 3: Percent of Firms by Firm Size Who Would be Likely or Unlikely to Provide Direct Cash Payments to Employees for Health Insurance, 2006



Thirty five percent of small firms with 10 or fewer employees said they would be very or somewhat likely to make cash payments to workers in lieu of negotiating with an insurance company in order to provide company based health insurance. The likelihood of the cash payment option did not gain support for larger firms and for very large firms-by Montana standards-of more than 100 employees. Very few of the 68 respondents in this firm size category indicated that they would be likely to provide a cash payment. Only 12 percent said they would be very or somewhat likely to offer cash payments in lieu of negotiating and providing health insurance.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

This section minimally documents activities related to Montana's health care marketplace because many of the questions asked in this section were not addressed by the continuation grant Steering Committee.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

This issue was not addressed by the first or continuation grant.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

This issue was not addressed by the first or continuation grant.

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

This issue was not addressed by the first or continuation grant.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

Table 10 shows the enrollment levels for the primary public programs in Montana during calendar years 2002-2005.

Table 10. Enrollment in Public Programs, Montana, Calendar Years 2002-2005

Program	CY 2002	CY 2003	CY 2004	CY 2005
Medicaid	78,881	81,984	84,663	84,650
Child (0-17 years)	42,178	44,756	46,809	47,076
Adult (18+ years)	36,817	37,355	37,987	37,716
CHIP	9,283	9,582	10,684	11,060
Medicare	140,156	142,457	144,995	146,145
State Employee Health Plan	31,537	31,157	30,402	30,851
Total	259,857	265,180	270,744	272,706

Notes: Medicaid and CHIP data are as of 10/11/06. Medicaid and CHIP figures represent monthly enrollment figures. Medicaid Adult and Child do not add to the total due to some individuals turning 18 during the year and being counted in both age groups. Medicare counts are from CMS National Health Accounts and include individuals with either Part A or Part B. State Employee Health Plan data are from the Health Care and Benefits Division of the Department of Administration.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

This issue was not addressed by the first or continuation grant.

3.6 How would universal coverage affect the financial status of health plans and providers?

This issue was not addressed by the first or continuation grant.

3.7 How did the planning process take safety net providers into account?

While the Steering Committee for the initial grant had a Safety Net Work Group to guide their recommendation development, the Steering Committee for the continuation grant includes a representative from the Primary Care Association to represent safety net providers. The universe of Montana's safety net was presented to the Steering Committee during the orientation of this continuation grant's Steering Committee.

Among the action arenas addressed in the recommendations put forth by this continuation grant's Steering Committee is the expansion of community health centers (CHC), a significant part of the safety net. Policy guidance has been proposed by the Steering Committee. In conjunction with the work of this grant, state legislation may be introduced to appropriate $2M in 2008 and $2M in 2009 to create two new non-federally-

funded CHCs. Further, another $450,000 is proposed to be appropriated for medical, mental health, and/or dental service expansions to existing federally qualified health centers (FQHCs) with an additional $450,000 proposed appropriation to provide grants to existing FQHCs.

3.8 How would utilization change with universal coverage?

This issue was not addressed by the first or continuation grant.

3.9 Did you consider the experience of other States with regard to: Expansions of public coverage; public/private partnerships; incentives for employers to offer coverage; regulation of the marketplace?

Yes.

One of SHADAC's products under the continuation grant was a report of health insurance access programs and policies in other states. The report identified and summarized public, employer-based and individual market health insurance coverage expansion initiatives that have been implemented in the four frontier states of Montana, Idaho, South Dakota and Utah. The final SHADAC report summarized the program highlights that stand out in each of the four states. They also issued a supplemental report of initiatives to improve health insurance coverage in five additional states. These reports (see Appendix II) were issued in July 2006, prior to the beginning of the SPG Steering Committee discussion on either new or amended (from the first SPG) recommendations and were a resource to committee members.

Further, throughout the life of the grant, numerous national articles were shared among the grant Project Team and Steering Committee members as they appeared in the national and local media.

Staff of Montana's SPG have engaged in email communication with SPG representatives from other states and have found the networking at the national SPG meetings to be beneficial. The two national meetings convened for SPG grantees were particularly useful relative to sharing information among states and providing opportunities for networking.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The recommendations resulting from the proceedings of the Steering Committee of the continuation grant are summarized in Appendix III of this report. They are explained in more detail in the document entitled the 2006 *Final Steering Committee Report* (see Appendix II).

The purpose of this section is to provide specific details about the key policy options selected by Montana during the first SPG. The answers to this Section will summarize updated information (progress) on the key options adopted as a result of the first SPG and first implemented in calendar years 2005 and 2006.

To address questions 4.1-4.13, the following tables summarize and update the core expansion options legislated in 2005 and implemented by Montana in 2005 and 2006. These tables were excerpted with updates from SHADAC's report, *Health Insurance Programs and Policies in Montana and Other Frontier States*.

Because some of the questions in Section 4 were not addressed by the first or continuation grant Steering Committee, they have not been answered or are answered only for specific policies in this Final Report. For example, questions 4.3 through 4.6 are answered only for specific policies and questions 4.7 through 4.13 are not answered. The reader is referred to the individuals listed in the tables as primary contacts for the answers to those questions.

Table 11: CHIP Program Expansion

Contact	Eligibility	Enrollment	Benefits	Updates
Jackie Forba Ph: 406-444-5288	Family income limit initially set and has remained at ≤150% FPL for children < 19 years One-month period of uninsurance required (some exceptions apply)	No enrollment cap effective July 2005 13,165 children enrolled as of 06/2006	**Benefits:** Benchmarked on state employee health plan; includes: • Inpatient/outpatient hospital • ER • Physician • Surgical • Lab and x-ray • Well-child /well-baby visits and immunizations • Prescription drugs • Mental health and substance abuse treatment • Hearing and vision exams • Dental ($350 maximum payment per benefit year) **Cost Sharing:** • No co-pays for families with incomes ≤100% FPL • Co-pays ($3-$25) for >100% FPL; annual family co-pay max is $215 per benefit year • No annual enrollment fee • No co-pays for well-baby/child care, immunizations and dental services **Continuous Eligibility:** Eligibility is determined every 12 months. An enrollee remains eligible unless child moves from state, moves in state and CHIP is unable to locate family, is eligible for Medicaid, is eligible for state employee benefit plan, is found to have other creditable health insurance, turns 19 in age, or becomes an inmate of public institution.	Expanded funding and enrollment in 2005 (increased state funding through a tobacco tax). **Barriers to CHIP removed:** • Discontinued 16-page universal application; implemented 4-page CHIP application. • Development of web-based interactive application to apply on-line (must still sign and mail application to CHIP). • Implementation of electronic report to CHIP of children denied or losing Medicaid so CHIP follow-up can occur. • Decreased time of uninsurance prior to CHIP enrollment from 3 months to 1 month. **CHIP outreach efforts undertaken:** • Ongoing statewide media campaign in 2006. • Update and training (including brochure insert and poster) for Tribal Health and Indian Health Services (IHS) staff on 7 reservations, spring and summer of 2006. • Update and training for community partners (CHIP Champions) in Billings and Missoula in spring, 2006. Partnerships with approximately 300 health care associations, health care providers, schools, and community organizations. • Direct mail campaign to potential CHIP families. • July 2005 survey of families not re-applying for CHIP.

Table 12: HIFA Demonstration Waiver

Contact	Eligibility	Enrollment	Benefits	Updates
Jo Thompson Ph: 406-444-2584 Montana's Waiver application at: www.dphhs.mt.gov	Uninsured Mental Health Services Plan (MHSP) participants ≤150% FPL Uninsured children ≤150% FPL Seriously emotionally disturbed (SED) youth ages 18-20, ≤150% FPL Working parents ≤200% FPL with Medicaid-eligible children Montana Comprehensive Health Association (MCHA) Premium Assistance ≤150% FPL Insurance Assistance for Uninsured Adults ≤ 21 With Children and Insurance Assistance for Uninsured Youth Aged 18-20 ≤150% FPL	Estimated: • 1,500 MHSP clients • 1,500 children • 300 former SED youth • 600 working parents • Funding approximately 60 additional MCHA slots • 1,200 working adults with children and working youth aged 18-20	**Benefits:** For MHSP and working parents (up to $2,000 in total value): • Premium assistance for employer-sponsored or private market insurance or Medicaid individual health care benefits For MHSP: • Limited acute psych inpatient For uninsured children: • CHIP-equivalent package For uninsured SED youth: • CHIP-equivalent package, • CHIP extended SED mental health benefits, • Waiver transitional mental health services includes intangible life skill training, and • Medication management and consultation. For MCHA: • High risk coverage under MCHA For adults with children and youth aged 18-20: • Employer plan coverage under Insure Montana **Cost Sharing:** • For Insure Montana: Yes, 20% • For MCHA: Yes, 20% • For MHSP: Yes • For SED youth: Same as CHIP program, yes for basic and no for extended mental health • For uninsured working adults: Yes • Co-pay the responsibility of recipient depending on chosen insurance health plan. If beneficiary chooses a Medicaid Health Care benefit, the following State Plan co-pays apply: • $1-$5 co-pays • $100 coinsurance on hospital stays • $25 monthly prescription max • No enrollment fee • No cost sharing for tribal members receiving services at Indian Health Service	Medicaid Redesign State legislation enabling waiver passed in 2005. Waiver submitted to CMS in July 2006; not yet approved as of date of this Final Report; state negotiations with CMS ongoing.

Table 13: Small Business Health Care Affordability Act

Contact	Eligibility	Enrollment	Benefits	Updates
Erin McGowan Fincham Ph: 406-444-4613 Program information available at: www.Insuremontana.org	Small businesses (2-9 full-time employees)	First-come, first-served basis 1,271 small businesses have joined the tax credit and premium assistance programs. 7,000 total Montanans are being served in purchasing pool.	For businesses not offering insurance: • The Small Business Health Insurance Pool is created. • Monthly premium incentive (applied to employer) and monthly premium assistance (applied to employee): incentive will average $75 per employee per month; assistance will be 20%-90% of premium. For businesses offering insurance: • Refundable tax credits in the amount of $100 per employee per month.	• Initiated in 2006. • Montanans receiving tax credits are receiving a yearly average amount of $4,917. • Premium assistance averages $100 a month. • Most of the workers make less than $30,000 a year and are getting health insurance for the first time. • A 2007 legislative proposal for continuing support for this program is in place.

Note: HIFA Waiver *includes the utilization of federal match dollars for those who would be Medicaid eligible up to 200% in an effort to cover more people targeted to workers with children.*

Table 14: Increased Medicaid Asset Test for Children

Contact	Eligibility	Enrollment	Benefits	Updates
Linda Snedigar Ph: 406-444-6676	Children 0-6 years at 133% FPL and 6-18 years at 100% FPL	Estimated at 1,000 children which is approximately one third of original estimate when program implemented.	Full Medicaid benefits as described in Section 2 of the Medicaid Program Information Handbook, available at: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml.	Montana's job market considerably improved; minimum wage increase has decreased number of eligibles even after moving CHIP children (with potential eligibility) to this program.

Table 15: Big Sky Rx Program

Contact	Eligibility	Enrollment	Benefits	Updates
Christina David Ph: 406-444-3008	State residency; enrolled in Medicare prescription drug plan; 200% FPL; not eligible for Medicaid, nor possessing 100% award from Low Income Subsidy (LIS).	4,500 applications and 3,000 beneficiaries as of June, 2006.	Monthly prescription drug premium assistance up to $33.11 with payments either going directly to the recipient or to the prescription drug plan.	Reluctance of Medicare Part D recipients to enroll in drug assistance program.

Table 16: Prescription Drug Plus Discount Program

Contact	Eligibility	Enrollment	Benefits	Updates
Dan Peterson Ph: 406-444-4144	State residency; household income up to 250% FPL; must lack prescription drug coverage or have inadequate prescription drug coverage.	Not applicable.	To be determined.	Program not yet begun.

The Big Sky Rx Program, Prescription Drug Plus Discount Program, CHIP expansion, and the increased asset test for children's Medicaid do have a mandatory (required in implementing legislation) referral to and coordination with other similar programs.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

Enrollment data are being collected across all of the operating policy options selected by Montana in 2005. The state's Medicaid data system (currently The Economic Assistance Management System, or TEAMS) is undergoing significant redesign changes and is being replaced by a new system, the Combined Healthcare Information and Medicaid Eligibility System (CHIMES). While procedures and data affiliated with the Medicaid program are therefore in transition, certain enrollment information (e.g., enrollment counts) are nonetheless available for monitoring the asset test change for relevant Medicaid children. For the CHIP program, waiting list, enrollment and disenrollment counts are available through the state's Kids Insurance Data System (KIDS). Application counts and rate of applicant eligibility are available via KIDS as well. The CHIP program also monitors their referrals to Medicaid.

Enrollment data also are being collected for the state's new programs, including Insure Montana and the Big Sky Prescription Drug programs. For both, program staff are monitoring applications and enrollment on a monthly basis. Information collected via the Insure Montana application form also is being stored in electronic format.

Because the HIFA waiver programs and the prescription drug discount program have not yet been implemented, enrollment processes and data systems have not been determined, and limited information presently exists regarding the types of data these programs will likely collect.

For additional information about program data, please see the *Data Plan for Evaluating Select Health Insurance Access Programs and Policies in Montana* produced by SHADAC under this grant (see Appendix II).

4.15 How (and how often) will the program be evaluated?

One of the products of this grant was the preparation of an evaluation data plan that is meant to serve as a starting point for evaluating the six health access initiatives passed by the 2005 Legislature. Potential data sources include program applications and application data systems, program enrollment data systems, budget forecast estimates, special program reports, program referral records, and national and state survey data.

The evaluation data plan does not prescribe a specific evaluation approach, but rather provides overarching evaluation guidance and outlines example evaluation questions, measures, and data sources for each of the six health access initiatives. The report encourages the state to first consider its evaluation needs and priorities and then, based on its decisions, build on the approach outlined in the *Data Plan for Evaluating Select Health Insurance Access Programs and Policies in Montana* (see Appendix II).

The DPHHS Planning, Coordination and Analysis Unit, who are officially designated as "the home" for continuing this effort to develop more health care coverage options (at the conclusion of this continuation grant), will oversee and coordinate the evaluation of the

key health coverage initiatives resulting from the 2005 Legislature and those that will come from the 2007 Legislature.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

The following table identifies the considerations in favor of and against each of the key expansion options legislated in 2005.

Table 17. Factors For and Against Montana's Expansion Options

Expansion Option	Factors For	Factors Against
Insure Montana Program	• Private market-based solution • New state funding from tobacco tax • Integration into Waiver concepts • Approximately 5,000 more lives covered	• Need to revise insurance laws • Limited federal match • Lack of competitive health insurance market • Challenges in establishing shared database with Departments of Administration and Revenue • Volatile health insurance market
Chip Expansion	• New state funding from tobacco tax • Access more federal funds • Administrative simplification • Reduces number of uninsured children in Montana • Increases access to healthcare for Montana children	• Limits on federal CHIP grant authority • Computer system re-configuration • Requires legislative approval to increase eligibility criteria and legislature is only in session every other year (e.g., 2007, 2009, etc.)
HIFA Medicaid Re-Design Waiver	• Leverages more federal Medicaid dollars • More recipient cost sharing to allow more people to take advantage • Strengthens and increases mental health services • Use of private market-based solution to pay for part of Waiver services • Expansion of benefits to a previously non-eligible population • Allows children on CHIP waiting list to access healthcare services sooner • Approximately 5,000 more lives covered, including the approximately 1,200 additional Insure Montana slots that will be available	• Challenges of negotiating with federal CMS; negotiations are cumbersome and time-consuming making implementation plans unreliable and generating reluctance from partners
Big Sky Prescription Drug Program	• New state funding from tobacco tax	• Reluctance of Part D Medicare recipients to enroll in plan • Lack of data sharing of potential enrollees from SSA and CMS to reach individuals in need
Increased Medicaid Asset Limit for Children	• Approximately 3,800 more children covered	• Challenges in re-designing data system (minimal because only a table change was required) • State Plan amendment needed • State rules change required • Policy changes and training for eligibility staff • Facilitating the transfer of children from CHIP who are now Medicaid eligible • Increased caseload in children's programs, potentially requiring more staffing
Prescription Drug Plus Discount Program	• New state funding from tobacco tax	• Reluctance of some drug manufacturers and PhRMA to form a state partnership for drug rebates because many drug manufacturers already have their own discount drug programs • Lack of success of discount drug programs in other states

Federal deficits, state budget crises, slow economies, rising costs and inflation create challenges for all expansion options.

During each of Montana's two SPG cycles the Steering Committee used a set of principles to guide their proceedings and to help them reach consensus. The following set of principles (similar to those used by the Steering Committee from the first SPG) guided the recommendation development of the continuation grant Steering Committee:

1. Support and develop actions that increase access to health care, health care coverage and prevention.
2. Continue to gather and monitor data to keep track of intersecting systems and to inform actions and decisions.
3. Define the problem(s).
4. Promote prevention and wellness to avert avoidable costs.
5. Maximize use of federal and state dollars and use methods to contain costs.
6. Pass the test of being fiscally responsible.
7. Keep it simple, administratively doable and practical for our sparsely populated, geographically large state.
8. Reduce existing system complexities.
9. Have basic benefits that are clearly defined that improve health status.
10. Cover those with the greatest need first.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed, and administrative actions such as waivers), and the remaining challenges.

See tables presented under questions 4.1 – 4.13.

There have been challenges in implementing the various initiatives. For example:

1. The Waiver application submission was delayed because the in-state approval process was delayed while DPHHS tried to assure that all parties were educated about the Waiver concepts and what their implementation would mean. Much time was allowed for input and response. The question/answer protocol between CMS and the state has also taken an extended period of time. The Waiver is still in negotiation with CMS.
2. The Insure Montana Program (HB 667) faced very short timelines for program implementation; longer than anticipated time needed by businesses to complete and return coverage applications for the Purchasing Pool; complications from the creation of the new information sharing database (with the Departments of Administration and

Revenue); and difficulty maintaining low rates and good coverage in a volatile health insurance market.

3. Montana is closely monitoring federal CHIP proposed reauthorization levels in FFY 2007, wanting to assure the provision of an annual allocation which will allow this state to continue to cover, at a minimum, the currently enrolled children.

   Some Montana families fail to apply for CHIP since they believe their income is over the program guidelines. CHIP provides eligibility information to those families to encourage them to apply for CHIP coverage. A further CHIP challenge is providing information to Native American families who may not realize their children may be covered by CHIP while also accessing health care services at IHS and tribal health facilities.

4. The reluctance of some major drug manufacturers to join the state in a partnership for drug rebates (because they already provide other forms of drug assistance and are hesitant to duplicate efforts) is a challenge facing the Drug Discount Program (SB 324). For this reason the program has not been implemented. The Big Sky Rx Program (a part of SB 324) is having a difficult time reaching Montanans enrolled in a Medicare Part D Program. There is speculation that because Part D has been complicated and this population has rarely been eligible for past State or Federal assistance (because they've been over on assets and/or income), they don't think they're eligible for Big Sky Rx and don't apply.

5. Improvement in Montana's job market and the increase in the minimum wage have decreased the number of children eligible for Medicaid through the asset test increase. Demand for it as another avenue for increasing the health care access for children has been lower than anticipated.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

The only policy option stemming from the first SPG not implemented was raising the CHIP FPL from 150% to 200%. Lack of available state dollars and state legislative support were the challenges in trying to increase the CHIP FPL.

4.19 How will your State address the eligible but not enrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

See right hand column entitled "Barriers to CHIP removed" and "CHIP outreach efforts undertaken" in Table 11 (the first table of this section) for efforts to increase enrollment in CHIP.

For the Medicaid Program, the following actions have been taken to increase and simplify enrollment:

- Develop a Medicaid-only application;
- Conduct targeted reviews to insure Native American income and resources are appropriately considered in determining eligibility;
- Continue presumptive eligibility and federal benefits training to raise awareness and facilitate Medicaid applications;
- Participate in Grandparents Raising Grandchildren conferences to promote awareness of Medicaid programs for children;
- Raise resource limit from $3,000 to $15,000 for the two largest children's Medicaid programs, covering children (0-6 at 133% FPL and 6-18 at 100% FPL); and
- Continue to refer children determined by CHIP staff to be potentially eligible for Medicaid to the Offices of Public Assistance for Medicaid eligibility determination.

All of these efforts involve collaboration with the county offices of public assistance, with the Native American population in Montana, and local public health programs.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

During the composition of the continuation grant application to HRSA, key state agencies were identified (DPHHS, DOLI, SAO) and involved by the team of individuals who drafted the grant application.

Subsequent to the awarding of this continuation grant, the Director of Montana's DPHHS appointed a 24-member SPG Steering Committee to create a comprehensive plan with specific short-and long-term actions that would lead to accessibility of affordable high quality health care coverage for all Montanans by the Year 2012.

The Steering Committee from the first SPG was the starting point for considering nominees for the continuation grant Steering Committee. Committee members included public and private sector leaders representing business and industry, the Governor's Office, the legislature, the private non-profit sector, the health care delivery industry, the health insurance sector, minority populations, state agencies, and health care consumers.

Also, a multidisciplinary Project Work Team including staff from the DPHHS, DOLI, and SAO was chosen to assist the grant director and contractors to: (1) continue to refine and create a sustainable source of data on the insurance status of Montanans, including

employer-based insurance; (2) analyze the impact of current policies and programs influencing access to health care coverage; and (3) develop and recommend possible policy options for consideration by the Steering Committee.

Achieving consensus was guided by ten principles developed by the Steering Committee prior to the process of developing recommendations. Those ten principles are stated in the answer to 4.16 above and at the beginning of the 2004 *Final Report to the Secretary* (see Appendix II).

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Public input was solicited at each Steering Committee meeting, with the final meeting exclusively focused on soliciting public input. The schedule of these meetings was always posted on Montana's DPHHS electronic calendar. Committee members who are familiar with or members of groups interested in the work of this grant were encouraged to forward all electronic communication (including documents/products of the grant) regarding this grant to those groups not currently on the list of "interested others" who regularly receive all information either emailed or mailed to the Steering Committee members.

All products of this grant were offered to the Steering Committee and Project Team members as drafts for input from them and the constituency they represented.

The University of Montana's BBER conducted a follow-up survey of the same employers surveyed three years earlier (with an additional sample of new employers to refresh the sample) to update information on health insurance from the employers' perspective. Questions were added to the state's 2006 BRFSS (and will be added to the 2007 BRFSS) to update information regarding health care access from the individual Montanan's point of view.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

All formal communication efforts with state and city/county media continued to be coordinated by the DPHHS Public Information Officer through the Governor's Office.

DPHHS developed and continues to update the web page devoted to the state planning grant efforts (see Appendix II).

Some Steering Committee representatives were involved in the Robert Wood Johnson Foundation's Cover the Uninsured Week in their local communities in May 2006. The DPHHS Director submitted a Letter to the Editor regarding the progress by Montana in trying to cover more of the state's uninsured with health care. Similar letters were also prepared for select association newsletters when solicited.

The Grant Director was interviewed as part of a public television presentation on the problems of the uninsured in Montana.

The Grant Director met with members of the public and private sector directly involved in increasing the number of insured Montanans to inform them of the work of the grant and request their assistance in the proceedings of the Steering Committee when necessary. These public and private representatives included an insurance brokerage specializing in advising private non-profit sector on best products for their members, the Director of the state's Health Care Benefits Division that oversees the state health insurance plan, and the benefits coordinator for the state's university health insurance plans, and who are not represented on the grant Steering Committee.

National and local news articles were electronically shared among Steering Committee members and staff as a means of helping local communities and the Steering Committee members become more informed participants in the solution to the problem of the uninsured.

Steering Committee members agreed to electronically share notes and products of their proceedings with both the organizations they individually represent and with other like organizations not represented on the Steering Committee.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

Please refer to the answer to this question on pages 37 and 38 of the 2004 *Final Report to the Secretary* (see Appendix II). While much of that answer is still applicable, much more policy progress has been made since the publication of that report two years ago.

As reported earlier, Montana's 2005 Legislature did in fact take most of the recommendations from the first SPG and incorporate them into legislation, becoming law with the aid of an increased tobacco tax, a pending Waiver application that will use formerly unmatched state dollars to match federal Medicaid dollars, pharmaceutical manufacturer rebates, and other revenue initiatives.

As a result of the first and continuation SPG and of including State Representatives and Senators in the discussion of health care in Montana, legislators' awareness has been raised as has their investment in the health and well being of their constituents. The SPG information has brought credibility to the data both DPHHS and the Insurance Commissioner use to respond to fiscal notes for legislation and analysis because often the resource of that information is the data collected through the SPG.

The current policy and political environments appear to be very amenable to further expand health insurance coverage to more Montanans. The Steering Committee has been informed of attempts that will be made during the 2007 Legislature to introduce bills with the primary intention of covering more Montanans with health care or insurance. There is a demonstrated overall political consensus of trying to cover more Montanans with health care or insurance.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating design?

Please refer to the answer to this question on page 39 of the 2004 *Final Report to the Secretary* (see Appendix II). It is still applicable. Overall the qualitative and quantitative data collection activities from the first grant: (1) described the characteristics of the Montana's uninsured, contributing to a deeper understanding of how health insurance coverage varies among different population groups within the state; (2) identified existing barriers preventing the uninsured from getting coverage; and (3) demonstrated how uninsured citizens' access to the health system is affected.

Adding to what Montana learned from the data collected during the first SPG (a baseline for Montana health care data) are the results from the 2004 and the 2005 BRFSS and the results of the follow-up 2006 Employer Survey, both of which are summarized earlier in this Final Report. The results of the 2006 Employer Survey were extremely reinforcing to the state's efforts to expand the Insure Montana Program (underway in the 2007 Legislature) and also supportive of the state's openness to looking at a variety of new ways to provide more health care insurance options for its citizens.

Overall the state specific data continues to be important to decision makers. The qualitative research (from the first SPG) identified stakeholder issues and helped guide the design of the recommendation document emanating from the Steering Committee of this continuation grant. In the future the state is committed to an annual review of the BRFSS results and studying how the DOLI will administer a regular survey to employers to assess their progress in providing health insurance coverage to their employees.

One of the main purposes of this continuation grant has been to institutionalize the data gathering activities to continue to guide future health care coverage policy in Montana. To that end, SHADAC's products (the memos to DPHHS on how to best expand the existing BRFSS to continue to monitor health care coverage challenges, suggestions regarding the future use of an employer survey, and the evaluation data plan) and the University of Montana follow-up Employer Survey have been and will continue to be particularly useful as resources in continuing the evolution of a solution to this problem.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

Please refer to the answer to this question on page 39 of the 2004 *Final Report to the Secretary* (see Appendix II). It is still applicable.

Also see last paragraph of answer to 6.1 in this report.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

Data collection activities have been completed as originally proposed.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

Using a state-based experienced vendor (the University of Montana's BBER) for the follow-up employer survey, a known out-of-state experienced vendor (Macro International) for the BRFSS, and the experienced state BRFSS staff for questionnaire design only enhances the successful response rates for these surveys.

During this continuation grant Montana also relied on SHADAC to provide guidance and specific recommendations on survey questions. Specifically, the memos that discussed trends in employer-sponsored health insurance data in Montana and how to use the BRFSS to annually monitor the uninsured in the state were very helpful. These memos were issued by SHADAC after conferring with the agencies and staff involved in these efforts (see Appendix II).

In their report, *Data Plan for Evaluating Select Health Insurance Access Programs and Policies in Montana* (see Appendix II), SHADAC identifies existing data sources that may be used to assess the success of several policy changes and new programs being implemented by the state. It also suggests possible methodologies for evaluating programs and policies.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the state have plans to conduct research?

Continuing health care access data collection either through the BRFSS and the DOLI Employee Benefits Survey on a regular basis (or some other potential household or employer surveys) will be a necessity as Montana continues to evolve its health care access policy. Also, defining who the underinsured are in Montana and developing a strategy to improve their insurance status or health care access would be beneficial.

The numbers of "uninsured" Montanans varies, depending on the data source utilized or referenced. If the federal government is going to push a universal health care agenda, a standard tool (to be utilized in all the states and funded by the federal government) for determining the number of uninsured is a necessity. There is a myriad of surveys (produced by state and national organizations) available for developing such a standard tool.

The potential for a more global or universal health care coverage approach in Montana may still have to be addressed. Issues such as the adequacy of existing health insurance products and the impact of self insured firms have not been addressed by research under this grant. It is unknown at this time whether the state has plans to conduct such research.

From this continuation grant, the state was able to budget funding for additional questions to be added to the 2007 BRFSS survey which is to be fielded through calendar year 2007. The BRFSS survey questionnaire will be modified with additional questions about health insurance coverage type/access/utilization for adults and children and additional employment characteristics to complement the existing questions and round out the data collection needs. A copy of the added questions is available on the DPHHS website (see Appendix II). It is hoped this information can be gathered on an ongoing basis to monitor the status of the uninsured if DPHHS can secure state funds to keep the questions on the BRFSS survey.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

Please refer to the answer to this question on page 40 of the 2004 *Final Report to the Secretary* (see Appendix II), which still holds some importance as Montana continues to design ways to better serve its residents with health care.

While there have been no proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort, the collaboration among the three state departments (DPHHS, DOLI and SAO) has been greatly strengthened. During the initial 12 months of this continuation grant, the state chose a "home" in the Office of Planning, Coordination, and Analysis within the DPHHS Director's Office for the continuation of the state planning grant-like activities. This new home will be responsible for continuing to oversee and coordinate efforts among the three state departments that increase health care access including health care insurance coverage for more Montanans. Anticipated activities to be undertaken by the Office of Planning, Coordination and Analysis are: formalizing of an agreement among the three agencies; regularly reviewing annual BRFSS results and a possible DOLI survey; and convening the Steering Committee as an advisory group to the three agencies.

It would not be unreasonable to anticipate possible change in the structure of health care programs as a result of SPG activities. The importance of being open to suggestions for organizational change has been a lesson learned.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Once again, the key lesson is involving the private sector (including insurance providers and the business community) in the effort to develop health policy that expands insurance coverage in the state. The private sector is involved not only through the SPG governing mechanism, but also as members of other state advisory groups connected to the DPHHS, DOLI and SAO, the three state entities committed to collaborating effective health policy development.

Also, private insurance companies (through the development of new health plans) have tried to be responsive to this potential market of the uninsured. See status report chart of recommendations in Section 4. Also, health insurance coverage is now a reality for previously uninsured Montanans. Within one year of implementation of the Insure Montana Program, more than 3,800 uninsured Montanans (employers, employees and family members) are receiving health coverage through a purchasing pool and two quality health plans from Blue Cross Blue Shield of Montana. Because of the increased demand for the Insure Montana Program, the 2007 Legislature is reviewing a proposal to expand this program.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

The three key recommendations (similar to those noted on page 40 of the 2004 *Final Report to the Secretary*) are:

- involve the private and public sector in health policy development;
- keep a broad cross section of the state's population involved in and informed about the process; and
- take the necessary time to solicit input from many entities as health policy is drafted.

6.9 How did your State's political and economic environment change during the course of your grant?

See response to question 5.4. The SPG process and information are what helped move health care coverage bills through the last session of Montana's Legislature in 2005 and will continue to do so in subsequent legislative sessions.

6.10 How did your project goals change during the grant period?

The project goals have not changed during this grant period.

6.11 What will be the next steps of this effort once the grant comes to a close?

The continuation grant is ending this month, February 2007. At this time Montana's 2007 Legislature is in session, and it is anticipated that legislative initiatives furthering the goals of this continuation grant will be in place.

Administratively the next steps are:

- Collect the grant documents and house them in one central location for future reference;
- Assure placement of grant documents on DPHHS website;
- Officially designate the DPHHS Office of Planning, Coordination and Analysis as the "home" of health policy development;
- Formalize agreement among the three state agencies (DPHHS, DOLI, and SAO);

- Continue regular administration of BRFSS and the DOLI Employee Benefits' Survey;
- Compile data, analyze combined data, report and make recommendations relating to the uninsured;
- Convene Steering Committee as advisory body to the three agencies listed above in development of health policy;
- Continue evaluation of 2005 legislative initiated programs to provide health care coverage to more Montanans; and
- Continue development of executive and legislative initiatives to provide adequate health care coverage to more Montanans long term.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

A federal waiver would be required if the state legislature and Governor approved DPHHS to cover parents of children enrolled in CHIP. CMS approval of a State Plan amendment to expand CHIP eligibility above the current 150% FPL would be required.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

During the continuation grant there were no coverage options not selected that would require changes in federal law. All the coverage options selected were finalized and organized according to whether they would be long term (i.e., needing further continuous discussion) or short term (with immediate legislative action possible).

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

Providing dollars to the states periodically for (minimally) a household and an employer survey would provide a continuous picture of the health insurance needs in the state.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

Again, conducting research to identify who the underinsured are and the differences between access to health care and health insurance coverage would assist states greatly in developing effective coverage programs.

SECTION 8. OVERALL ASSESSMENTS OF SPG PROGRAM ACTIVITY

8.1 What is the likely impact of program activities in the near future? What were the major impediments and facilitators for improved outcomes? Include specifics about changes in budgetary environment, changes in political leadership, etc.

There will be continuation grant Steering Committee recommendations introduced in the 2007 Legislature. The original ideas leading to the recommendations were initiated by some members of the Steering Committee who brought their ideas for support to the Steering Committee while concurrently soliciting sponsorship from legislators for introduction in the 2007 session of Montana's Legislature. See those recommendations grouped in "the short term/possible immediate legislative areas" in the 2006 *Final Steering Committee Report* (see Appendix II).

Also, the "home" for continuing SPG-like activities will be the Office of Planning, Coordination and Analysis in the DPHHS Director's Office.

8.2 What is the state's current view of most feasible expansion options? What direction was deemed most feasible and why?

See the 2006 *Final Steering Committee Report* (see Appendix II).

8.3 What do you foresee to be the sustainability of programs implemented as a result of the SPG program, or the likelihood that programs currently under consideration will be implemented?

The programs implemented as a result of the 2005 Legislature (see Section 4 of this report) are very sustainable, if the state continues to commit the dollars currently available and being used. Some new programs, such as the Insure Montana program have created an increase in demand for the financial assistance offered, and legislators and the Governor have to decide if the extra dollars requested to extend these new programs and new program approaches are worth the investment.

8.4 Did your SPG program activity create an impetus to change your state's Medicaid program via a waiver, changes in eligibility or cost-sharing?

SPG activity, especially the data collected, assisted the state in developing the Waiver it submitted in July 2006.

8.5 Please describe the realities of state decision-making regarding insurance expansion in terms of things that facilitate and inhibit policy changes.

Because bi-annual (every other year) legislative sessions do not always keep pace with the momentum necessary to move issues along, Montana's Legislature does have a protocol involving interim legislative committees that require progress reporting and sometimes proposals in preparation for the upcoming legislative sessions. But this every other year meeting of Montana's Legislature is not always timely for the implementation of some programs. Federal level budget allocations and policy decisions can have a major impact on state programs during a non-state legislative year, e.g., SCHIP reauthorization.

8.6 Concretely, what was the value of funding the data collection analysis? How were the results used to shape political thinking and build consensus on ways to cover the uninsured? What is the value of data being re-collected and at what frequency?

Please see answers to 6.1, 6.2 and 6.5.

8.7 In terms of the data collection activities pursued through the SPG grant, are there certain ones you would do differently based on experience?

No.

8.8 How have stakeholder groups evolved over time? In hindsight, what are the central components to putting and keeping together a successful steering committee?

Montana is fortunate to have had and continues to have private and public sector individuals who have been involved in these discussions and problem solving on behalf of Montanans with little or no health insurance. Many of these individuals serve not only on the Steering Committee for this SPG, but also serve on other groups that advise the state and the Governor on Medicaid, CHIP, Insure Montana Program and the state health plan providing good cross fertilization of ideas when necessary.

Central components to a good stakeholder group are getting a broad cross section of people

- involved in and knowledgeable about the problem;
- committed to finding a solution or solutions; and
- with a willingness to follow and sometimes assume knowledgeable and assertive leadership.

8.9 What activities will be discontinued as a result of the SPG grant coming to a close?

With the conclusion of the SPG activities, there are no dollars specifically allocated to continue the activities, especially the data collection and technical assistance activities. However, there is a commitment from Montana to house similar activities in the Office of the Director of DPHHS (specifically in the Planning, Coordination and Analysis Unit) and to continue convening the existing Steering Committee of private and public expertise.

One of the best products of this continuation grant is the close collaboration among the three state agencies directly involved with the issues surrounding the expansion of health care coverage to all Montanans and their collaboration with the private sector. That will continue through the formality of an interagency agreement and the informality of just plain working together on health care projects of mutual interest.

Also, see answer to 6.11.

8.10 Highlight specific lessons about potential policy options that could be used by HHS and states to shape future activities.

In the continuity of developing policy options, a state uses a good strategy if it assigns one or two people at the state level to maintain continuity in this process of evolving a solution to the problem/s of the uninsured. SPG states should have to indicate who the contact people will be in continuing this effort. Montana has done that by providing "a home" for the continuation of this process (without the HRSA SPG dollars) in the DPHHS Office of Planning, Coordination, and Analysis. See recommendation #1 in the 2006 *Final Steering Committee Report* (see Appendix II).

8.11 Please comment on how helpful the site visit, availability to talk/email with AcademyHealth staff and general technical assistance of AcademyHealth was to your project.

The AcademyHealth State Coverage Initiatives Program (SCI) is and has been particularly helpful to policy makers (on the grant Steering Committee who are both in the private and public sectors). It's the goal of Montana to stay connected to the SCI.

8.12 Please comment on how helpful the HRSA SPG grantee meetings were to your project?

The SPG grantee meetings were invaluable in terms of networking and sharing ideas that worked and didn't work.

During the period of Montana's first SPG, the state was very reliant on the information generated at those meetings. During the period of Montana's continuation SPG, the networking and idea sharing encouraged at those meetings was most beneficial.

8.13 Please comment on how helpful the technical assistance from SHADAC was to your project?

Montana was very dependent on the resources available from SHADAC. Their technical assistance and products were extremely influential in shaping the progress of Montana's efforts to solve its significant problem. Montana would have struggled without the assistance of SHADAC. Montana had an excellent working relationship with the SHADAC staff, and it is hoped that it will continue post grant in some form.

8.14 Please comment on how helpful the Arkansas Multi-State Integrated Database System was to your project, (if applicable).

Until this continuation grant when one of the Project Team leaders overseeing the Grant Director's work pursued their assistance, Montana did not receive much assistance from the Arkansas Multi-State Database System other than ringbinders of instructions.

Montana believes that each state should have had the opportunity to individually subcontract with Arkansas and require the specific assistance necessary for their state, versus HRSA automatically taking the dollars from each state's grant award and giving it to Arkansas.

8.15 Please comment on how useful the Agency for Healthcare Research and Quality's technical assistance and survey work (e.g. MEPS-IC) was to your project.

Montana staff focused attention on the value of the MEPS-IC to Montana's efforts for the first time during this continuation grant. It will probably continue to be a reference point in some of Montana's research.

8.16 Please comment on the long-term effect (if any) of your state's SPG program on future efforts to improve coverage via: a) data collection (e.g., surveys, focus groups, etc.), b) data analysis (e.g., modeling, actuarial analysis), c) political understanding/education, and d) approaches and structure for collaboration.

All the work accomplished via a-d above will be housed in an existing unit (known as the Office of Planning, Coordination and Analysis) of the DPHHS Director's Office and will be sustained in some form with the guidance of the existing Steering Committee from the continuation SPG.

APPENDIX I: BASELINE INFORMATION

Please see tables providing baseline information in Section 1 of this report and on pages 43-46 of the 2004 *Final Report to the Secretary* (see Appendix II).

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

The website containing all the information regarding Montana's first and continuation grants is: www.dphhs.mt.gov/uninsured/index.shtml.

Documents noted in this report and available on the Montana DPHHS web site include:

2005 State Planning Grant

2006 *Final Steering Committee Report*, December 2006
http://www.dphhs.mt.gov/uninsured/stateplanningspgrecommendations.pdf

2006 Employer Survey on Health Insurance Coverage in Montana–Final Report, December 2006
http://www.dphhs.mt.gov/uninsured/spgemployersurvey122006.pdf

Health Insurance Access Programs and Policies in Montana and Other Frontier States, July 2006
http://www.dphhs.mt.gov/uninsured/pdffiles/policesprograms07192006.pdf

Data Plan for Evaluating Select Health Insurance Access Programs and Policies in Montana, December 2006
http://www.dphhs.mt.gov/uninsured/dataevaluationplan.pdf

Monitoring Trends in Employer-Sponsored Health Insurance Data in Montana, August 2006
http://www.dphhs.mt.gov/uninsured/pdffiles/monitoringtrendssurveymemo.pdf

Suggested Questions to Include in Subsequent Montana BRFSS Questionnaires, September 2006
http://www.dphhs.mt.gov/uninsured/pdffiles/suggestedquestionsbrfss.pdf

Using the BRFSS to Monitor the Uninsured in Montana, September 2006
http://www.dphhs.mt.gov/uninsured/pdffiles/brfsstomonitoruninsured.pdf

Montana Employer Survey, December 2005
http://www.dphhs.mt.gov/uninsured/pdffiles/employersurveymemo.pdf

2002 State Planning Grant

Final Report to the Secretary, April 2004
http://www.dphhs.mt.gov/uninsured/pdffiles/mtfinal102004.pdf

Montana Strategic Plan to Provide More Affordable Health Care Coverage, August 2004
http://www.dphhs.mt.gov/publications/stateplanninggrant.pdf

Final Report: Household Survey and Employer Survey Findings about Health Insurance Coverage in Montana, 2004
http://www.dphhs.mt.gov/uninsured/pdffiles/healthreportfinal.pdf

Focus Group Report (Part 1), 2003
http://www.dphhs.mt.gov/uninsured/pdffiles/focusfinalpart1.pdf

Focus Group Report (Part 2), 2003
http://www.dphhs.mt.gov/uninsured/pdffiles/focusfinalpart2.pdf

Executive Summary for Focus Groups, 2003
http://www.dphhs.mt.gov/uninsured/pdffiles/focusgroupexecutivesummary.pdf

Final Report: Key Informant Interviews on Health Care Access and Insurance in Montana, 2003
http://www.dphhs.mt.gov/uninsured/finalreportkeyinformant.pdf

APPENDIX III: SPG SUMMARY OF POLICY OPTIONS

The full recommendations resulting from this continuation grant are outlined in the 2006 *Final Steering Committee Report* (see Appendix II). The first three recommendations resulting from this continuation grant are administrative in nature (supporting the infrastructure, valuing/building the healthcare workforce, and weaving the integration of the Native American People into every action) and are not listed in Table III-1, on next page. Those directly providing health care coverage to Montanans are included in Table III-1, along with the policy options from Montana's original SPG grant.

Table III-1. Summary and Status of Policy Options from Montana's Original and Continuation SPG Grants

Option Considered	Target Population	Estimated Number of People to be Served	Status of Approval	Status of Implementation	Estimated Number of People Served (if implemented)
Continuation Grant:					
Healthcare for Montanans who provide healthcare	People working 20 hours or more per week providing Medicaid-funded in-home Personal Assistance and Private Duty Nursing services who are currently without any kind of healthcare coverage (public or private)	1,700 people	2007 legislative proposal	Not applicable	Not applicable
Extend age of dependent child coverage	All Montanans ages 19 through 25	Not determined	2007 legislative proposal	Not applicable	Not applicable
Primary prevention of chronic disease	Montanans at high risk for diabetes and Montanans with multiple cardiometabolic risk factors	38,000 Montanans	2007 legislative proposal	Not applicable	Not applicable
Integration of incentive-based wellness into employer-based health insurance	State of Montana employees	9,000 state employees	Steering Committee Recommendation to Joan Miles, DPHHS Director	Not applicable	Not applicable
Expand services through Community Health Centers	Montana residents with incomes <200 FPL	325,617 Montanans	2007 legislative proposal	Not applicable	Not applicable
Continue support for Insure Montana Program	Small businesses with 2-9 employees	4,000-6,000 Montanans	2007 legislative proposal	Not applicable	Not applicable
Expand CHIP to 200% FPL	Uninsured eligible children below 200% FPL	5,000 children	2007 legislative proposal	Not applicable	Not applicable
Standardize children's Medicaid to 133% FPL	Children ages 6-19 years	10,772 children	Steering Committee recommendation to Joan Miles, DPHHS Director	Not applicable	Not applicable

Option Considered	Target Population	Estimated Number of People to be Served	Status of Approval	Status of Implementation	Estimated Number of People Served (if implemented)
Original Grant:					
CHIP program expansion	Uninsured children (< 19 years) in families whose income is ≤ 150% FPL	Approximately 3,000 children	Approved in 2005	Fully implemented and ongoing as of July 2005	13,165 as of June 2006
HIFA Demonstration Waiver	Uninsured Mental Health Services Plan (MHSP) participants ≤150% FPL Uninsured children ≤150% FPL Seriously emotionally disturbed (SED) youth ages 18-20, ≤150% FPL Working parents ≤200% FPL with Medicaid-eligible children Montana Comprehensive Health Association (MCHA) Premium Assistance ≤150% FPL Insurance Assistance for Uninsured Adults With Children ≤ 21 and Uninsured Youth Aged 18-20 ≤150% FPL	Estimated: • 1,500 MHSP clients • 1,500 children • 300 former SED youth • 600 working parents • Funding approximately 60 additional MCHA slots • 1,200 working adults with children and working youth aged 18-20	Not yet approved by CMS	Not applicable	Not applicable
Premium assistance and tax credits (Insure Montana Program)	Small businesses (2-9 full-time employees); No employee may make >$75,000/year other than owner.	47,000 estimated eligible people	Approved in 2005	Implemented January 2006	• 1,271 small businesses: approximately 700 businesses enrolled in the tax credit program and 560 businesses enrolled in the premium assistance program; • 7,000 total Montanans are being served in purchasing pool.
Increased Medicaid asset test for children	Children aged 0-6 years at 133% FPL and 6-18 years at 100% FPL	3,600 children	Approved in 2005	Implemented July 2006	Approximately 1,000 children

Option Considered	Target Population	Estimated Number of People to be Served	Status of Approval	Status of Implementation	Estimated Number of People Served (if implemented)
Big Sky Rx Program	State residents enrolled in Medicare prescription drug plan; ≤200% FPL; and not eligible for Medicaid, nor possessing 100% award from LIS.	20,000 Medicare beneficiaries	Approved in 2005	Implemented January 2006	4,500 applications and 3,000 beneficiaries as of June 2006
Prescription Drug Assistance Program	State residents with household income up to 250% FPL who either lack prescription drug coverage or have inadequate prescription drug coverage	60,000 residents	Approved in 2005	Not implemented as of yet	Not applicable